Ohio | Board of Executives of Long-Term Services & Supports

CE Waiver Form

Section A – Personal Information			
First Name:	Middle Name/Initial:	Last Name:	
Mailing Address – Number & Street		City:	
State:	Zip Code:	County:	
Home Telephone w/Area Code:	E-mail Address (Optional)	LNHA #	
Amt. of hours requesting to be waived			

I,_____, affirm to the Board that the information
(Print Name)
provided in the document is true and accurate to the best of my knowledge. I understand that this waiver, if granted, is only valid for the period specified by the Board. I also understand that I cannot practice as an LNHA until I have fulfilled my CE requirements and my annual registration has been renewed by the Board. I have attached a written explanation of my request for a waiver of the continuing education requirements.

_____ _____
Signature *Date*

Section B – Physician Information		
Physician Name:	License Number and state of Issue:	
Mailing Address – Number & Street		
City:	State:	Zip Code:
Work Telephone w/Area Code and Extension:	E-mail Address (Optional)	

Section C – To Be Completed By Your Treating Medical Professional(s).

I,_____, affirm to the Board that the above
(Print Name)
mentioned individual was not able to participate in any continuing education activities between

_____ and _____ .
Date *Date*

_____ _____
Physician Signature *Date*

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